STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155510	A. BUILDING 00 B. WING	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTURY VILLA HEALTH CARE	705 NORTH MERIDIAN STREET GREENTOWN, IN46936

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This survey was for Recertification and State Licensure Survey. Survey Dates: August 22, 23, 24, 25, 2011 Facility Number: 000549 Provider Number: 155510 AIM Number: 100267470 Survey Team: Tammy Alley, RN TC Toni Maley, BSW Donna M. Smith, RN Victoria Bickle, RN (August 22 and 23, 2011) Census Bed Type: SNF: 12 SNF/NF: 60 Residential: 35 Total: 107 Census Payor Type: Medicare: 19 Medicaid: 28 Other: 60 Total: 107 Sample: 15 Supplemental Sample: 11 Residential Sample: 7	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on August 31, 2011 by Bev Faulkner, RN			
F0176 SS=D	An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. Based on record review, observation, and interview, the facility failed to ensure assessments were completed to determine competency and safety for 3 of 3 residents observed to self administer nebulizer treatments in a sample of 15. (Resident # 2, # 59 and # 27) Findings include: 1. The record for Resident # 2 was reviewed on 8/24/11 at 10:15 a.m. Current physician orders for August 2011 indicated an order for Duoneb inhalation to be given every 4 hours for bronchospasms and lacked an order to self administer medications. During the initial tour on 8/22/11 at 9:50 a.m., the resident was in her room sitting	F0176	1) Residents #2, 59 & 27 with nebulizer treatments were assessed for self-administratation & able to self administer.2) All other current residents receiving nebulizer treatments are being assessed for the ability to self-administer.3) A policy & assessment have been initiated for self-administration of nebulizer treatments only.4) Assess upon admission, new orders & PRN to determine capability of self-administration. CNAs will be educated to not turn off nebulizer machine. They will seek the nurse. Nurses will be educated to notify administration if turned off by CNA. QA each self-administration monthly to ensure capability. QA will be ongoing.An interdisciplinary department meeting is conducted weekly to discuss resident issues such as falls, therapy, mood/behaviors, dietary needs,	09/23/2011

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	in her wheelchair. Her nebulizer was on and laying on the over the bed table in front of the resident. On 8/24/11 at 1:40 p.m., the resident was in her room in her wheelchair with her nebulizer treatment on and she was holding the mouth piece in her mouth. No staff were present in her room. The record lacked an assessment to self administer medications. On 8/24/11 at 2:00 p.m., during an interview, the Director of Nursing indicated she did not have a resident in the facility who self administered their medications. 2. The record for Resident # 59 was reviewed on 8/23/11 at 9:45 a.m. Current physician orders for August 2011 indicated an order for Duoneb inhalation to be given 4 times daily for bronchospasms and lacked an order to self administer medications. During the initial tour on 8/22/11 at 9:40 a.m., the resident was in her room in her wheelchair holding her nebulizer mouth piece in her mouth with the treatment on. No staff were present in the room.		etc. A weekly check off list will be implemented to be utilized at this meeting to address and correct concerns/findings as they occur. These findings will be discussed at each quarterly QA meeting.	

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	The record lacked as assessment to self administer medications. On 8/24/11 at 2:00 p.m., during an interview, the Director of Nursing indicated she did not have a resident in the facility who self administered their medications. 3. On 8/22/11 at 3:20 p.m., medication pass was observed. RN #6 was observed to prepare Resident #27's nebulizer treatment. After she added the medication, Budesomide (bronchospasm), to the mouthpiece medication container, she turned the nebulizer on and handed the mouthpiece containing the medication to Resident #27. He was observed to be using the mouthpiece as RN #6 left the room. She indicated to the resident she would be back in a few minutes. On 8/22/11 at 3:35 p.m., Resident #27 was observed without the nebulizer handheld device with the nebulizer machine running. The resident had turned his call light on. On 8/22/11 at 3:40 p.m., during an interview, Resident #27 indicated he had turned his call light on as he had completed the nebulizer treatment. He also indicated the CNA, who had answered the call light, had turned the			

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	nebulizer machine off for him. On 8/24/11 at 2:30 p.m., during an interview, RN #6 indicated she would set up the medication in a resident's nebulizer, turn the nebulizer on and tell him she would be back in a few minutes to check on him. On 8/24/11 at 2:00 p.m., during an interview, the Director of Nursing indicated she did not have a resident in the facility who self administered their medications. Resident #27's record was reviewed on 8/24/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and bronchospasm. The significant Minimum Data Set assessment, dated 6/16/11, indicated the resident was able to make his own decisions. The physician order, dated 6/20/11, was Budesonide (Pulmicort) 0.5 milligrams (mg) per 2 milliliters suspension inhalation 1 inhalation 2 times a day for bronchospasm. There was no order to self-administer or an assessment to self-administer medications. 4. The "SELF-ADMINISTRATION OF DRUGS" policy was provided by the Director of Environmental Services on			

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	8/24/11 at 1:40 p.m. This current policy indicated the following: "PROCEDURE 1. Each resident wishing to self-administer medications will be evaluated for his/her capability for administering medications to themselves. 2. A written order must first be placed in the resident's medical record for self-administration of medications.... ...4. If the resident desires to self-administer medications, an assessment is conducted by the nurse to assess the resident's cognitive, physical and visual ability to carry out this responsibility....." 3.1-11(a)			
F0221 SS=D	The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, interview and record review, the facility failed to ensure a resident was free from the use of physical restraints without an assessment for its use, indication of a medical symptom being treated by the device, evidence that the restraint in use was the	F0221	1) Resident #53 was assessed & found to be unable to release self-releasing seatbelt on command at different times throughout the day. An order was obtained for restraint.2) Residents with self-releasing seatbelts were assessed to determine ability to release on a consistent basis.	09/23/2011

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	less restrictive device available to treat a medical symptom or condition, a signed consent for the use of a physical restraint for 1 of 1 resident reviewed for restraint use in a supplemental sample of 11 (Resident #53). Findings include: 1.) Resident #53's record was reviewed on 8/24/11 at 9:50 a.m. Resident #53's current diagnoses included, but were not limited to, Alzheimer's disease and hypertension. Resident #53 had a current 8/11 physician's order, which originated 11/22/08, for a "self-release Velcro seat belt when in w/c [wheelchair] for safety." Resident #53 had a 6/6/11 care plan problem regarding the potential for falls. An approach to this problem was self-release seat belt when in wheelchair. Resident #53 had an 8/24/11 "Fall Assessment: Predisposition for Falling" which indicated the resident was a moderate risk of falling. The assessment indicated the resident had "intermittent confusion."		One received an alarm self-releasing device. One order was obtained for restraint due to falls not related to cognition.3) Residents with self-releasing seatbelts will be assessed quarterly with each MDS & PRN to determine the ability to self-release upon command.4) MDS Nurse will QA upon initiation of order, with each MDS & PRN. QA will be ongoing.In response to pg. 7, items a, b, c, d:a) Upon assessment, resident #53 was unable to release consistently.b) Consent signed when order for restraint for resident #53 obtained.c, d) Resident #53 has intermittent confusion per Fall Assessment & has diagnosis of Alzheimers. Self-releasing seatbelt was released & resident stood 3 times without assist from wheelchair. Staff were able to intervene. Resident #53 has poor safety cognition.An interdisciplinary department meeting is conducted weekly to discuss resident issues such as falls, therapy, mood/behaviors, dietary needs, etc. A weekly check off list will be implemented to be utilized at this meeting to address and correct concerns/findings as they occur. These findings will be discussed at each quarterly QA meeting.	

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Resident #53 had a 6/6/11, current, quarterly, Minimum Data Set Assessment, which indicated the resident was severely cognitively impaired and rarely or never made decisions.

Resident #53's clinical record indicated she had not had a fall in the past 6 months.

Resident #53's record lacked:

a.) An assessment for the use of a self-release seat belt restraint,

b.) A consent for the use of the self-release seat belt physical restraint,

c.) Evidence that a self- release belt restraint was the least restrictive means available to treat a medical symptom or condition,

d.) Identified medical symptoms or conditions which were being treated by the use of a self-release seat belt restraint.

Resident #53 was observed on 8/22/11 at 11:15 a.m., 8/23/11 at 7:45 a.m., and 8/23/11 at 12:30 p.m., in her wheelchair with a Velcro front closer restraint in place.

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	On 8/24/11 at 8:56 a.m., Activity Assistant #12 asked Resident #53 to unfasten her front Velcro closure seat belt. Resident #53 pulled at the side on the belt which lacked a fasten. She stated "I don't know how to get the lid off." She continued to tug at the tab which was not a fastener and indicated she could not release her belt. Review of a facility provided, current, 10/02, policy titled "Physical Restraints" which was provided by the Director of Environmental Services on 8/24/11 at 1:10 p.m., indicated the following: "Types of Restraints: ...seatbelt... Before a resident is restrained, the facility must demonstrate the presence of a specific medical symptom that would require the use of restraints, and how the use of restraints would treat the cause of the symptom and assist the resident in reaching his/her highest level of physical and psychosocial well-being." "If after a trial of less restrictive measure, [sic] the facility decides that a physical restraint would enable and promote greater functional independence, the following must be done before the restraint is used:			

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	Staff must explain to the resident, family member, or legal representative prior to use. [sic] If the resident, family member, or legal representative agrees to this treatment alternative, then the restraining device will be used for the SPECIFIED PERIODS for which the restraint has been determined to promote the resident's general well-being." During an 8/24/11, 3:00 p.m., interview, the Director of Nursing indicated Resident #53's self-releasing seatbelt had not been considered a restraint and was considered an enabling device. She indicated restraint assessments and consents had not been completed due to it's consideration as an enabler. She indicated she had not considered the residents fluctuation in mental functioning impacting the resident's ability to release the seat-belt throughout the day. 3.1-26(a) 3.1-26(o) 3.1-26(r)			
F0223 SS=A	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review, the facility failed	F0223	1) Incident was reported timely to	09/23/2011

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	to prevent physical abuse from occurring for 1 of 15 residents reviewed for physical abuse in a sample of 15. (Resident # 200) Findings include: During a review of a reportable occurrence on 8/24/11 a 10:20 a.m., the report indicated on 5/22/11 at 1:30 p.m., Resident # 200 and her daughter reported that during her care, CNA # 11 had been rough with her. The resident indicated the CNA had transferred her to the toilet and bumped her head on the wall and sat her down on the toilet "real hard." Immediately, the Assistant Director of Nursing had the CNA come to the room for identification and she was identified by the resident and was immediately suspended pending investigation. The Administrator was notified and the event was reported to the Indiana State Department of Health, the Ombudsman, and Adult Protective Services. A progress note, dated 5/22/11, indicated the resident's family and physician was notified and a physical assessment was completed that revealed a red bump on the resident's forehead and the resident was educated to notify someone if anything bothers her. The resident's condition was followed up on for several days without concern. The CNA was terminated		all appropriate agencies as is required.2) No other residents affected/identified.3) All employees receive abuse training upon hire, annually & ongoing. As has always been the practice of this facility, should an event occur, the employee(s) in question is suspended until at such time the investigation into the occurrence has been completed with appropriate action, such as termination, taken. If the occurrence is obvious the employee(s) maybe terminated immediately. 4) Facility will continue to provide abuse training to all employees. Any incidents of abuse (or unusual occurrence reporting) will be discussed in the quarterly QA meeting. QA will be ongoing.	

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	because the investigation revealed the aide had been rough with the resident prior, but the resident had not reported it to anyone. CNA # 11's employee file was reviewed on 8/24/11 at 10:15 a.m. The CNA had pre-employment references and a criminal history check that was negative. She had abuse and resident rights training within the past 30 days prior to the event. A 3/97 policy titled "Resident Abuse Policy" was provided by the Administrator on 8/22/11 at 1 p.m., and deemed as current. The policy indicated "...each resident is to be treated with the utmost courtesy and tact, and has the right to be free form verbal, sexual, physical and mental abuse, neglect, corporal punishment, involuntary seclusion and misappropriation of resident property...." 3.1-27(a)(1)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the	F0309	1) Nurse's response was she had	09/23/2011

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	facility failed to ensure a Peripherally Inserted Central Catheter (PICC line) was removed with assessment of the catheter and site for 1 of 1 resident reviewed with a PICC line removed in a sample of 15. (Resident # 10) Findings include: The record for Resident # 10 was reviewed on 8/22/11 at 1:15 p.m. A progress note, dated 7/11/11 at 3:22 p.m., indicated an order was received to discontinue the resident's PICC line due to non-use. A Progress note, dated 7/12/11 at 1:13 a.m., indicated the PICC line was discontinued and the resident tolerated the procedure well. The note lacked length of the catheter or if the tip was intact. There was no site assessment. Additional information was requested on 8/23/11 at 4:30 p.m., from the Director of Nursing, regarding an assessment of the PICC line and site. During interview on 8/24/11 at 2:45 p.m., the Director of Nursing indicated the nurse who pulled the PICC line had checked the tip, but had not measured the catheter. She indicated this information had not been documented in the record.		checked tip & intact but failed to document on resident #10.2) No other residents affected/identified.3) Nurses will be educated regarding policy for PICC removal.4) Documentation will be placed on the TAR to measure length & intact tip upon removal of PICC line. Facility charge nurse will be responsible for ensuring appropriate documentation. QA will be ongoing.An interdisciplinary department meeting is conducted weekly to discuss resident issues such as falls, therapy mood/behaviors, dietary needs, etc. A weekly check off list will be implemented to be utilized at this meeting to address and correct concerns/findings as they occur. These findings will be discussed at each quarterly QA meeting.	

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	An August 2008 policy titled "Peripherally Inserted Central Catheter (PICC) Removal" was provided by the Director of Environmental Service on 8/24/11 at 1:10 p.m., and deemed as current. The policy indicated: "...23. Measure catheter length and assess catheter tip to ensure that entire catheter was removed...32. Documentation in the medical record includes, but is not limited to:...Length and condition of catheter...site assessment...." 3.1-37(a)			
F0315 SS=E	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review, and interview, the facility failed to ensure the anchored urinary catheter tubing and drainage bag was positioned in a manner to prevent the potential for infection for 4 of 4 residents reviewed for proper placement of anchored catheter tubing and drainage bag in a sample of 15. (Resident # 10, # 66, # 50 and # 68)	F0315	1) Resident #10 Foley replaced with new type for low beds and snapped catheter bags. Resident #66, discharged. Residents #50 & 68 - all CNAs to be educated by 09/23/11 regarding new equipment & appropriate placement of tubing to prevent touching floor.2) No other residents affected/identified.3) All CNAs to be educated by 09/23/11	09/23/2011

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	Findings include: 1. The record for Resident # 10 was reviewed on 8/22/11 at 1:15 p.m. Current physician orders for August 2011 indicated an order for an anchored catheter. A plan of care, dated 7/11/11, indicated a problem of potential for urinary tract infections related to a Foley catheter. A laboratory report, dated 7/8/11, indicated the resident had 15-25 white blood cells in his urine with a normal range of 1-14 and the urine had 1 + bacteria. The physician ordered Bactrim DS (antibiotic) twice daily for 7 days. On 8/22/11 at 9:50 a.m., during the initial tour with the Director of Nursing, Resident #10 was up in his wheelchair in the therapy room. The resident's anchored catheter tubing was on the floor under his wheelchair. At that time, the Director of Nursing was informed the tubing was on the floor, she then informed therapy staff to position the tubing off the floor. On 8/23/11 at 7:12 a.m., Resident # 10 was in his low bed, with his anchored catheter tubing on the floor at the bedside.		regarding implementation of low profile drainage bag with anti-flux valve & appropriate placement of catheter tubing in bag.4) CNAs will be educated monthly x6 months then quarterly thereafter. QA will be ongoing.An interdisciplinary department meeting is conducted weekly to discuss resident issues such as falls, therapy, mood/behaviors, dietary needs, etc. A weekly check off list will be implemented to be utilized at this meeting to address and correct concerns/findings as they occur. These findings will be discussed at each quarterly QA meeting.	

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	Cloudy, yellow urine was in the tubing. At 7:15 a.m., CNA # 13 was informed the anchored catheter tubing was on the floor. She immediately went to the room and adjusted the tubing off the floor. She indicated during interview at that time, the tubing should be positioned off the floor with a piece of Velcro. 2. The record for Resident # 66 was reviewed on 8/24/11 at 8 a.m. Current orders for August 2011 indicated an order for an anchored urinary catheter. A plan of care, dated 8/23/11, indicated a problem of potential for urinary tract infections related to a Foley catheter. A progress note, dated 8/15/11 at 7:22 p.m., indicated the resident's urine was brown to red in color and the physician was notified. A laboratory report, dated 8/16/11, indicated the resident had a urinary tract infection and was started on Keflex 500 milligrams (antibiotic) twice daily for a urinary tract infection. On 8/22/11 at 3:08 p.m., Resident # 66 was in his room in his wheelchair. His anchored catheter tubing was on the floor under his wheelchair. The urine in the			

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	tubing was a cloudy yellow. At 3:10 p.m., CNA # 14 was informed the tubing was on the floor. At that time during interview, she indicated the tubing should be positioned under the chair off the floor with a Velcro strap. 3. On 8/22/11 at 11:30 a.m., Resident #50 was observed in his wheelchair with his family member propelling him toward the nurse. She indicated the resident's Foley catheter tubing needed to be repositioned as it was dragging on the floor. Resident #50's Foley catheter tubing was observed on the floor with yellow urine observed in the catheter tubing. On 8/22/11 at 6:20 p.m., Resident #50's Foley catheter tubing was observed on the floor as he sat at the dining room table in his wheelchair. Yellow urine with white sediment was observed in the catheter tubing. Resident #50's record was reviewed on 8/23/11 at 11:40 a.m. The resident's diagnoses included, but were not limited to, urinary tract infection. The quarterly Minimum Data Set assessment, dated 7/04/11, indicated the resident had an indwelling catheter. The physician order, dated 5/03/11, was			

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	for a supra pubic catheter. The physician order, dated 6/17/11, was Keflex (antibiotic) 500 milligrams 2 times a day for 1 week for urinary tract infection. The continence assessment, dated 5/14/11, indicated the indwelling catheter was due to urinary retention. The urinalysis, dated 6/17/11, indicated the urine was positive for nitrites and was "loaded" with white blood cells and red blood cells and bacteria. The urine culture had multiple organisms present and was considered to be contaminated. No repeat urine culture was indicated. 4. On 8/22/11 from 1:30 p.m. to 1:50 p.m., Resident #68's transfer was observed. As the resident was prepared for the stand up lift, the resident's Foley catheter (F/C) bag was hung on a knob of the stand up lift elevating the F/C bag above the bladder level. As the resident was stood up with the help of the lift, CNA #2 moved the F/C bag between the knee pad and metal frame. Very cloudy, yellow urine was observed in the F/C tubing. As the resident was lowered to her bed, the resident had been standing on her F/C tubing during this transfer. In bed, the resident's F/C bag was first placed at the end of the bed and then			

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picked up above the bladder level to thread it through the pant leg to complete the removal of the resident's pants before it was lowered below the bladder level on the bed frame. At this same time during an interview, CNA #1 indicated the F/C bag and tubing should not touch the floor or be kinked and was to be kept below the bladder level.

Resident #68's record was reviewed on 8/23/11 at 3:50 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus Type II and hypertension. The quarterly Minimum Data Set assessment, dated 7/07/11, indicated the resident had an indwelling catheter.

The continence assessment, dated 6/02/11, indicated the indwelling catheter was due to urinary retention.

The urinalysis, dated 8/01/11, indicated the urine was positive for nitrites with above normal amount of white blood cells, red blood cells, and bacteria.

The physician order, dated 8/01/11, was Keflex (antibiotic) 500 milligrams orally 2 times a day for 7 days for a urinary tract infection.

On 8/25/11 at 11:00 a.m., during an

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	interview, the Assistant Director of Nursing indicated no urine culture had been completed with the 8/01/11 urinalysis. 5. The "MANAGING RESIDENTS WITH AN INDWELLING CATHETER AND CLOSED DRAINAGE BAG" policy was proved by the Director of Environmental Services on 8/24/11 at 1:10 p.m. This current policy indicated the following: "MANAGING RESIDENTS WITH AN INDWELLING CATHETER AND CLOSED DRAINAGE BAG PURPOSE 1. To empty urine from the bladder. ...PROCEDURE ...5. Prevent introduction of organisms through the distal end of the drainage system. This will insure unconstricted flow at all times. ...c) Keep the collecting bag below the bladder level; never allow it to touch the floor d) Check the drainage system for kinks and other mechanical causes of obstruction....."			

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F0322 SS=D	3.1-41(a)(2) Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, interview, and record review, the facility failed to ensure a resident's gastrostomy tube (G-tube) placement was checked prior to medication administration for 1 of 1 resident reviewed with G-tube medications in a sample of 15. (Resident #10) Findings include: On 8/24/11 at 11:35 a.m., medication pass was observed. LPN #10 was observed to prepare Resident #10's medications, which included Bromocriptine (prescribed for diabetes mellitus) and Carafate liquid medication (to treat ulcers). Next, LPN #10 was observed to unclamp and then administer these oral medications per G-tube. No G-tube placement check was observed before the administration of these medications. At this same time during an interview, LPN #10 indicated she checked G-tube placement 1 time a	F0322	1) Placement of g-tube will be checked prior to administration of meds.2) No other residents affected/identified.3) Nurses to be educated by 09/23/11.4) DON or ADON will observe 1x/week x1 month, all shifts, for proper placement. Documentation will be added to licensed nurse orientation checklist regarding g-tube placement. QA will be ongoing.An interdisciplinary department meeting is conducted weekly to discuss resident issues such as falls, therapy, mood/behaviors, dietary needs, etc. A weekly check off list will be implemented to be utilized at this meeting to address and correct concerns/findings as they occur. These findings will be discussed at each quarterly QA meeting.	09/23/2011

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	shift, and the resident's tube feeding had been turned off at 10:00 a.m., this morning. Resident #10's record was reviewed on 8/22/11 at 1:15 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident and diabetes. The physician order, dated 7/17/11, was Carafate 1 gram per 10 milliliter per enteral tube before meals and at bedtime for an ulcer. The physician order, dated 7/17/11, was Bromocriptine Mesylate (Parlodel) 2, five milligram capsules, 3 times a day for adult onset diabetes mellitus. The "ANCHORING GASTROSTOMY TUBE" policy was provided by the Director of Environmental Services on 8/24/11 at 1:20 p.m. This current policy indicated the following: "...PURPOSE A gastrostomy maintains hydration and provides nutrition for a resident who is unable to take them normally. ...PLACEMENT CHECK ...Placement of tube is to be checked prior to each medication and feeding administration....."			

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	3.1-44(a)(2)			
F0328 SS=D	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.			
	Based on observations, interview, and record review, the facility failed to ensure a resident was assessed prior and after a nebulizer treatment was administered for 1 of 2 residents observed during medication pass observations in a sample of 15. (Resident #27) Findings include: On 8/22/11 at 3:20 p.m., medication pass was observed. RN #6 was observed to prepare Resident #27's nebulizer treatment. After she added the medication, Budesomide (to treat bronchospasms), to the mouthpiece medication container, she turned the nebulizer on and handed the mouthpiece	F0328	1) Policy to reflect assessment before/after nebulizer treatment.2) Identified per orders & assess before/after treatment.3) Licensed nursing staff will be educated by 09/23/11.4) QA documentation wkly x4 wks to ensure compliancy. QA will be ongoing.1) Meds to be administered on early AM med pass. Attempts will be made to change Omeprazole to Zantac to alleviate the timeframe required for Omeprazole.2, 3) Med time changed.4) Admission chart audit will monitor for med ordered as referenced above. QA will be ongoing.1) Z-Track for Resident #69 was not indicated by pharmacy nor on Infed vial to administer with Z-Track. Indicated IM or IV. 2) No other	09/23/2011

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	containing the medication to Resident #27. He was observed to be using the mouthpiece as RN #6 left the room. She indicated to the resident she would be back in a few minutes. On 8/22/11 at 3:35 p.m., Resident #27 was observed without the nebulizer handheld device with the nebulizer machine running as RN #6 was observed to continue to pass her medications. The resident had turned his call light on. On 8/22/11 at 3:40 p.m. during an interview, Resident #27 indicated he had turned his call light on as he had completed the nebulizer treatment. He also indicated the CNA, who had answered the call light, had turned the nebulizer machine off for him. On 8/24/11 at 2:30 p.m., during an interview, RN #6 indicated she would set up the medication in a resident's nebulizer, turn the nebulizer on and tell him she would be back in a few minutes to check on him. She also indicated if she needed to assess a resident, she would listen to his lung sounds. Resident #27's record was reviewed on 8/24/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and		residents affected.3) Licensed nursing staff will be educated on proper administration of IM & Z-Track by 09/23/11.4) DON or ADON to QA administration 1x/month x3 months. QA will be ongoing.An interdisciplinary department meeting is conducted weekly to discuss resident issues such as falls, therapy, mood/behaviors, dietary needs, etc. A weekly check of list will be implemented to be utilized at this meeting to address and correct concerns/findings as they occur. These findings will be discussed at each quarterly QA meeting.	

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	bronchospasm. The significant Minimum Data Set assessment, dated 6/16/11, indicated the resident was able to make his own decisions. The physician order, dated 6/20/11, was Budesonide (Pulmicort) 0.5 milligrams (mg) per 2 milliliters suspension inhalation, 1 inhalation, 2 times a day for bronchospasm. The "NEBULIZER USE" policy was provided by the Director of Environmental Services on 8/24/11 at 1:15 p.m. This current policy indicated the following: "Using the Nebulizer * Listen to lungs, take pulse and respirations before beginning treatment. * Switch pump on and hold nebulizer level. * Sit resident up straight and exhale completely. * Have resident seal lips on mouthpiece. * Have resident inhale slowly, deeply and completely. * Do not allow resident to tire himself/herself. * Listen to lungs, take pulse and respirations after completing treatment....."			

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	3.1-47(a)(6)			

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F0332 SS=E	The facility must ensure that it is free of medication error rates of five percent or greater. Based on observations, record reviews, and interview, the facility failed to ensure a medication error rate of less than 5% for 5 of 15 residents observed receiving medications. 6 errors in medication were observed during 42 opportunities for error in medication administration. This resulted in a medication error rate of 14.28 %. (LPN #'s 3, 8, 9, and 10) (Resident #'s 2, 7, 50, 69, and 71) Findings include: 1. On 8/22/11 from 3:55 p.m. to 4:20 p.m., medication pass was observed. LPN #8 was observed to set up and give Resident #2 her nebulizer treatment, Iprat-Abut (bronchospasm), at this time. Resident #2's record was reviewed on 8/24/11 at 10:15 a.m. The resident's diagnoses included, but were not limited to, chronic airway obstruction, edema, and hypertension. The physician order, dated 7/10/11, was Ipratropium-Albuterol 0.5 milligram (mg) per 3 milliliter (ml)- 2.5 mg (3) mg per 3 ml solution inhalation per updraft every 4	F0332	1) Resident #2 discharged.2) No other residents affected/identified.3) Licensed nursing staff will be educated on timeliness of med pass & insulin coverage by 09/23/11.4) DON or ADON to QA timeliness 1x/wk x4 wks & quarterly thereafter. QA will be ongoing.An interdiscilplinary department meeting is conducted weekly to discuss resident issues such as falls, therapy, mood/behaviors, dietary needs, etc. A weekly check off list will be implemented to be utilized at this meeting to address and correct concerns/findings as they occur. These findings will be discussed at each quarterly QA meeting.	09/23/2011

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	hours and was scheduled at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m., for bronchospasm. The August medication record also indicated these same times for the administration of this medication. The "GERIATRIC MEDICATION HANDBOOK Eighth Edition" indicated the following: "Medication Administration and Medication Errors ...Steps of Medication Administration ...* Accurate medication administration (i.e., right drug, right patient, right dose and dosage form, right time)...." 2. On 8/22/11 at 4:32 p.m. during medication pass, LPN #3 was observed to give Resident #7 her insulin coverage for a blood sugar of 251. The resident received 6 units subcutaneously in the left arm of Novolog (diabetes mellitus) at this time. On 8/22/11 at 5:45 p.m., Resident #7 was observed to have drank a 1/2 glass of tomato juice. At this same time during an interview, she indicated she received the tomato juice between 5:30 p.m. and 5:40 p.m.			

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	On 8/22/11 at 5:50 p.m. during an interview, Dietary Aide #5 indicated she had started to serve the drinks in the dining room at 5:20 p.m. On 8/22/11 at 6:17 p.m., Resident #7 was observed to receive her meal tray. Resident #7's record was reviewed on 8/24/11 at 10:35 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus Type II. The physician's order, dated 5/16/11, was Humalog 100 unit (u) per milliliter (ml) solution subcutaneous (subq) per sliding scale 2 times a day and was scheduled for 7:30 a.m. and 5:30 p.m. The sliding scale was as follows: 51 - 150 = 0 u; 151 - 200 = 2 u; 201 - 250 = 4 u; 251 - 300 = 6 u; 301 - 350 = 8 u; and 351 - 400 = 10 u. 3. On 8/22/11 at 4:42 p.m. during medication pass, LPN #3 was observed to give Resident #50 his insulin coverage for a blood sugar of 211. The resident received a total of 8 units subcutaneously in the left arm at this time. On 8/22/11 at 5:15 p.m., Resident #50 was sitting at the dining room table waiting his dinner. No drinks, snacks, meal tray was observed.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

On 8/22/11 at 5:35 p.m., Resident #50 had now received his meal tray and drinks and had his tray set up for him.

On 8/22/11 at 5:40 p.m., Resident #50 was observed to not be eating. After CNA #4 encouraged verbally the resident to eat, he gave him a bite to eat.

Resident #50's record was reviewed on 8/23/11 at 11:40 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus Type II.

The physician order, dated 7/26/11, was Novolog 100 unit (u) per milliliter (ml) solution subcutaneous (subq) 4 u, 2 times a day and was scheduled for 11:30 a.m. and 5:30 p.m.

The physician's order, dated 8/21/11, was Novolog 100 unit (u) per milliliter (ml) solution subcutaneous (subq) per sliding scale and was scheduled for 11:30 a.m., 5:30 p.m., and 9:00 p.m. The sliding scale was as follows: 151 - 200 = 2 u; 201 - 250 = 4 u; 251 - 300 = 6 u; 301 - 350 = 8 u; and 351 - 400 = 10 u.

The "PDR (Pharmacy Drug Reference) 2010 edition Nurse's Drug Handbook" indicated the administration of Novolog intravenously or subcutaneously in

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	abdominal wall, thigh, or upper arm should be given immediately before a meal. 4. On 8/23/11 at 8:10 a.m., medication pass was observed. LPN #9 was observed to prepare and give Resident #71's her oral medications. These medications included, but were not limited to, Levothyroxine (hypothyroidism) 75 micrograms and Omeprazole (gastroesophageal reflux) 40 milligrams. The resident was observed to have eaten 1/2 of her breakfast. Resident #71's record was reviewed on 8/24/11 at 9:50 a.m. The resident's diagnoses included, but were not limited to, hypothyroidism and gastroesophageal reflux disease. The physician order, dated 3/18/2010, was Omeprazole 40 milligrams (mg) take 1 daily in the a.m. The physician order, dated 4/05/2010, was Levothyroxine sodium 75 micrograms every day in the a.m. The "PDR (Pharmacy Drug Reference) 2010 edition Nurse's Drug Handbook" indicated the administration of Omeprazole should be taken before eating, and Levothyroxine should be taken 1 hour before breakfast.			

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On 8/23/11 at 11:05 a.m., during an interview, LPN #9 indicated the "PDR (Pharmacy Drug Reference) 2010 edition Nurse's Drug Handbook" was the medication reference used for the nurses.

5. On 8/23/11 at 10:25 a.m., medication pass was observed. After LPN #10 completed her preparations to administer Resident #69's intramuscular (IM) medication, Infed (anemia), she was observed to pinch up an area of the left upper buttock, and without drawing back on the needle to check for blood return, she then injected the IM medication straight into this pinched up area and removed the needle.

On 8/24/11 at 11:32 a.m. during an interview, LPN #10 indicated she should have given the IM iron medication, Infed, by Z-track. She indicated when giving an IM medication after injecting the needle, one should check for blood by pulling back on the syringe before injecting the medication.

Resident #69's record was reviewed on 8/24/11 at 9:40 a.m. The resident's diagnoses included, but were not limited to, anemia.

The physician's order, dated 8/08/11, was

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	Infed 2 cubic centimeters intramuscular, 2 times a month, and was scheduled for the 9th and the 23rd of the month. The 2010 Nursing Spectrum Drug Handbook indicated the medication, Infed, should be injected intramuscularly by the Z-track method into an upper outer quadrant of the gluteal muscle. 6. The "INTRAMUSCULAR INJECTIONS (IM)" policy was provided by the Director of Environmental Services on 8/24/11 at 2:20 p.m. This current policy indicated the following: "Z Track Injection 1. Use same procedure for IM injection with the exception of the following: A. use only the upper outer aspect of the gluteous maximus (buttock) for Z-track injection. B. Compress the SC (subcutaneous) tissue and displace the SC tissue laterally before injection. C. Insert the needle straight into muscle while the skin is still displaced laterally. D. Inject the medication. E. Before releasing the tissue, wait about ten seconds after the needle has been withdrawn. F. Do not massage the injection site....."			

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	7. The "INTRAMUSCULAR INJECTION" policy was provided by the Director of Environmental Services on 8/24/11 at 1:15 p.m. This current policy indicated the following: "An intramuscular injection is the injection of a small amount of solution into the muscle by means of a syringe and needle. ...Procedure ...quickly insert the needle into the tissue. 21. Apply traction on the plunger. If blood appears in the syringe, pull the syringe back slightly to remove the needle from the blood vessel. Retest until no blood appears. 22. Inject the solution into the muscle....." 8. The "TIMES MEDICATIONS ARE GIVEN" policy was provided by the DON on 8/22/11 at 10:30 a.m. This current policy indicated the following: "EARLY AM 3 - 6 AM; AM 6:30 - 10:30 AM; AFTERNOON 11 AM - 2 PM; PM 2:10 - 7:30 PM; HS 8 - 10 PM; NOC 12 - 2:30 AM. The above times should be followed			

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	except when the physician orders medication to be given at a specific time....." 3.1-48(c)(1)			

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F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observations, interview, and record review, the facility failed to ensure effective infection control practices related to handwashing, glove use, use of scissors and handling of medications were	F0441	1) Employees will be educated on proper handwashing & glove usage during/after care.2) No other residents known to be affected/identified.3) Nursing staff will be educated on handwashing,	09/23/2011

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	implemented during 6 of 9 observations which included personal care with incontinent bowel movement (Resident #70), dressing change (Resident #37), and during medication pass (Resident #'s 1, 2, 10, 56, 26, 27, 64, 35, 24, 70, and 23). This involved the following nursing staff CNA #1, RN #6, LPN #'s 3, 7, 8, and 10. Findings include: 1. On 8/22/11 from 1:15 p.m. to 1:25 p.m., Resident #70's personal care was observed. With gloved hands, CNA #1 was observed to cleanse the resident's rectal area. The resident had been incontinent of brown bowel movement. CNA #1 with the same gloves then proceeded to reposition the resident on her side with a bolster, position the resident's Foley catheter tubing on the bed, covered her up, and then uncovered her feet, put her heel protectors on, and again repositioned her. Next, she removed her gloves and raised the resident's head of bed using the bed controller, picked up her used water basin and went into the resident's bathroom where the basin was emptied and put away. She returned to the resident's bedside and gave the resident her call light. She was observed to put the resident's supplies away, bag the used linen and trash before handwashing was		glove usage & cleaning scissors before/after use. Nurses are aware of standard of practice. Continuing education is provided to maintain proper universal precautions/procedures. Nurses will be educated on proper med pass procedures. Will be educated to use med cart to administer individually to each resident & will not pass eye drops from white basket nor carry eye drops or Advair in uniform pockets.4) DON or ADON to QA wkly, all shifts, x3 months, quarterly & ongoing thereafter.An interdisciplinary department meeting is conducted weekly to discuss resident issues such as falls, therapy, mood/behaviors, dietary needs, etc. A weekly check off list will be implemented to be utilized at this meeting to address and correct concerns/findings as they occur. These findings will be discussed at each quarterly QA meeting.	

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	observed. On 8/22/11 at 1:50 p.m. during an interview, CNA #1 indicated one should handwash before and after glove use and before and after resident care. She also indicated one should change gloves; for example, during a bed bath after mouth care, before peri-care, and when changing tasks. 2. On 8/22/11 from 3:00 p.m. to 3:15 p.m., Resident #37's dressing change to her left upper arm skin tear was observed. LPN #3 was observed to remove a pair of scissors from her pocket, cut the soiled gauze dressing and remove it. After the treatment was completed, the skin tear area was covered by a dressing followed by a gauze wrap. LPN #3 was observed to use the same pair of scissors to cut the gauze to complete the dressing. No cleansing of the scissors was observed. At this same time during an interview, LPN #3 indicated she should had cleaned her scissors before she used them to cut the clean gauze to complete the dressing change. 3. On 8/22/11 from 11:10 a.m. to 11:20 a.m., medication pass was observed. As LPN #7 prepared Resident #56's oral medications, she was observed with her bare hands to open the capsule and pour			

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	the contents of the capsule into a medication cup. This medication was mixed with applesauce and given to the resident. After giving this resident her oral medication, LPN # 7 prepared to medications for Resident #29, LPN #7 reapplied Resident #29's oxygen nasal cannula to her nose before handgel was observed used. 4. On 8/22/11 from 12:05 p.m. to 1:10 p.m., medication pass was observed. LPN #7 was observed to give Resident #27 his oral medication in applesauce. She returned to her medication cart and obtained Resident #56's eye drops container before she was observed to handwash. In preparation, LPN #7 was observed to remove the resident's eye drops from the container and place the container on the resident's bed. After the eye drops were given, the eye drops were returned to the same container and then to her marked drawer in the hallway medication cart. Next, Resident #64's medications were given. LPN #7 with gloved hands assisted Resident #64 with her Advair (bronchitis) inhaler, finishing with the mouth rinse and threw the cup away. With the same gloves, LPN #7 then gave the resident her eye drops and put the bagged Advair and eye drops in the container in her pocket as she helped the			

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resident to her bed. The medications were then removed from her pocket and put into the medication cart drawer.

5. On 8/22/11 from 3:20 p.m. to 3:35 p.m., medication pass was observed. RN #6 was observed to enter Resident #27's room. The hand held oral nebulizer mouthpiece was observed uncovered on the bedside table prior to the preparation of this nebulizer treatment. At this same time, a white basket of eye drops that RN #6 carried into his room was placed on a table in his room as she prepared and handed Resident #27 his mouthpiece and started his nebulizer treatment. The eye medications were for Resident #'s 35, 24, 64, 56, 70, and 23. Next, RN #6 was observed to carry the same white basket of eye drops to Resident #70's room and set it on a table. She then removed her eye drops from the white plastic basket, administered the eye drops, and put the eye drops into her uniform pocket. She then entered Resident #35's room placing the white basket of eye drops on the table and removing Resident #35's eye drops, administered them, and dropped them into her pocket. At this same time during an interview, RN #6 indicated she put the eye drops into her uniform pocket after she administered them to keep track of which eye drops she had given. She then

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	continued to Resident #56 for her eye drops administration carrying the same white plastic basket. 6. On 8/22/11 from 3:55 p.m. to 4:20 p.m., medication pass was observed. LPN #8 was observed to set up and give Resident #2 her nebulizer treatment. After LPN #8 completed the treatment and lung assessment, she was observed to return to the nurse's station for documentation. No handwashing/handgel use was observed. 7. On 8/23/11 at 8:05 a.m., LPN #3 was observed to be removing the capsules from a medicine cup with her fingers. As she obtained the capsules from the medicine cup, she opened the contents into a separate cup. She then added applesauce to the powder medications and to the rest of the pills and administered it to Resident #1. 8. On 8/24/11 at 11:35 a.m., medication pass was observed. In preparation of Resident #10's medications, LPN #10 was observed to open the medication capsules, Bromocriptine, with her bare fingers into a medication cup. This medication was administered to Resident #10 via gastrostomy tube. 9. The "HANDWASHING" policy was			

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	provided by the Director of Environmental Services on 8/24/11 at 1:10 p.m. This current policy indicated the following: "Handwashing is the most effective way to prevent transfer of microorganisms from resident to resident and employee to employee. ...Employees should clean their hands and exposed portions of their arms after any of the following: ...* Before and after caring for each resident when there has been close physical contact. ...* Other appropriate times (i.e., before leaving resident room if personal contact or bedmaking)....." The "PROTECTIVE BARRIER" policy was provided by the Director of Environmental Services on 8/24/11 at 1:10 p.m. This current policy indicated the following: "PROCEDURE Universal Precautions are to be used by all employees whose work includes the potential contact with blood, body fluids or materials contaminated by the blood or body fluids of any resident.			

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...3. Examination gloves shall be removed and discarded after contact with each resident, fluid, item or surface. Hands should be washed after gloves are removed.

...Gloves will be readily available at all times. Hands shall be washed in between each resident care whether gloves are worn or not....."

The "GERIATRIC MEDICATION HANDBOOK Eighth Edition" indicated the following:

"Medication Administration and Medication Errors

...Infection Control

There is potential for the medication nurse to transmit infection while moving from one patient to the next during medication passes. Hands should be either washed with antimicrobial soap or rubbed with an approved alcohol-based gel both before and after the administration of medications or treatment to residents.

...Other infection control procedures should include...Tablets and capsules should not be poured into the nurse's hand or touched during the medicine pass. The

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	nurse should wear gloves when cutting tablets in half or touching them for any other reason....." 3.1-18(l)			
R0000				
	The following residential findings were cited in accordance with 410 IAC 16.2-5.	R0000		
R0154	(k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview and record review, the facility failed to maintain sanitary conditions of the ice machine, located in the kitchen. This potentially could affect 34 of 34 residents, residing in the assisted living area, consuming meals/drinks, served from the kitchen, at least one time per day. Findings included: The kitchen tour was conducted on 8/22/11 at 11:15 a.m., with the Food Service Supervisor (#32). At 11:40 a.m. on 8/22/11, the ice machine	R0154	1) Ice machine was cleaned upon finding, 08/26/11. Preventive maintenance had previously been completed 05/12/11.2) No residents affected/identified.3) Dietary staff will check/document daily & report any concerns/adverse findings to maintenance staff.4) Dietary manager will QA wkly & PRN with routine preventive maintence continuing every 6 months per manufacturer's recommendation. QA will be ongoing.	09/23/2011

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	lid was opened and a visual inspection identified a black and red substance on the ice making apparatus. A clean paper towel was used to wipe the substance from the apparatus. The paper towel had a slimy, red and black substance on it. The Food Service Supervisor (#32) was present and observed the substance on the paper towel. The Food Service Supervisor (#32) indicated, during an interview at that time, she would contact maintenance to clean the ice machine. She also indicated maintenance cleans the ice machine every 6 months. The maintenance cleaning records for the ice machine, received and reviewed on 8/23/11, indicated the ice machine had been cleaned every 6 months, per manufacturer's recommendation. An interview with the Maintenance Supervisor (#33) on 8/23/11 at 2:00 p.m., indicated the ice machine may need cleaned more frequently. An interview with the Residential/Assisted Living Administrator (#30) and the Charge Nurse (#31), on 8/23/11 at 3:20 p.m., indicated that all (34) residents consumed meals/drinks, from the kitchen, at least one time per			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155510	A. BUILDING 00 B. WING	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	day.			